Attachment A

SPECIALIZED SERVICES REQUEST FORM

YOUTH_____JIRMS_____DOB_____DORM_____

FROM:_____DATE OF REQUEST:_____

I. PLEASE INDICATE APPROPRIATE SERVICES:

____ PSYCHIATRIC EVALUATION
____ SUBSTANCE ABUSE TREATMENT
____ INDIVIDUAL THERAPY
____ COUNSELING
____ BEHAVIOR MANAGEMENT
____ EDUCATIONAL ASSISTANCE
____ PSYCHOLOGICAL EVALUATION
____ PRE-RELEASE PROGRAM
____ GROUP THERAPY
____ RECREATION THERAPY
____ OTHER (SPECIFY)_____
____ EDUCATIONAL SUPPORT_____
(Specify Curriculum)

II. REASON(S) FOR REFERRAL: (Check all that apply)

____ MEDICATION CHECK
____ ASSESS NEED FOR MEDICATION
____ FURLOUGH/EARLY RELEASE REQUEST FOR EVALUATION
____ COURT ORDERED EVALUATION
____ HALLUCINATIONS
____Auditory ____Visual
____ FIGHTING
____# TICKETS WITHIN 30 DAYS
____ DEPRESSION
____ PREVIOUS PSYCHIATRIC HOSPITALIZATION
____ ANGER PROBLEMS
____ SUBSTANCE ABUSE
____ BEREAVEMENT ISSUES
____ SLEEP DISTURBANCE
____ POOR PARTICIPATION IN ACTIVITIES
____ SUICIDE ATTEMPT WITHIN LAST ____Week ____Month ____Year
____ SUICIDE ATTEMPT OVER ONE YEAR
____ SUICIDE GESTURE WITHIN LAST ____Week____Month____Year
____ SUICIDE GESTURE OVER ONE YEAR
____ CURRENT SUICIDE IDEATION
____ SUICIDE IDEATION WITHIN LAST ____Week____Month____Year
____ SUICIDE IDEATION OVER ONE YEAR
____ SELF-MUTILATION HISTORY
____ CURRENT SELF-MUTILATION
____ ATTENTION/ACTIVITY IN CLASSROOM
____ OTHER (Specify)_____

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Please indicate following:

____ Is Youth currently on MHMO?
____ Has Youth been on MHMO more than seven (7) days?
____ Has Youth ever been on MHMO?

COMMENTS:_____

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III. REFERRED TO:

____ PSYCHIATRIST
____ SOCIAL WORKER
____ SCHOOL PERSONNEL
____ SOCIAL SERVICES
____ PSYCHOLOGIST
____ RECREATION THERAPIST
____ PHYSICIAN

IV. REVIEWED AND APPROVED: _____ **DISAPPROVED:** _____

COMMENTS:

_____

_____

SIGNATURE: _____ DATE: _____
Corrections Program Manager

V. SERVICE PROVIDER ACTION TAKEN:_____

_____

_____

SIGNATURE: _____ DATE: _____
Service Provider's Signature

cc Case Record
Principal